

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 11, 2003
10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Context for Medicare spending -- Anne Mutti

MR. HACKBARTH:.....The first topic is the context for the Commission's work, the context for Medicare spending. Anne?

MS. MUTTI: As you might recall earlier this year in the March report we had an introductory chapter that focused on Medicare spending characteristics and trends, factors driving growth, trends in beneficiary resources, and comparisons with other sources of health care spending.

We initiated this survey of the health care spending and budgetary environment because we felt that it was important to recognize the larger context in which Medicare operates and we felt that it would help us in our assessment of the potential impact of Medicare's recommendations.

For the 2004 March report we plan to include a similar overview. This year we plan to broaden it to include not only spending trends and characteristics but also information on access to care and more detailed information on beneficiary resources and out-of-pocket spending.

Today's presentation focuses on the spending trends and the availability of supplemental insurance. Supplemental insurance relates both to access and out-of-pocket spending. But to large extent, today's presentation is an update on material in last March's report. And in following presentations later this fall, we'll get to more detailed information on access and on beneficiary resources and out-of-pocket spending.

Another point to note at the onset of this is that we, like last year or this past year, we plan to highlight our assessment of each recommendation by MedPAC on program spending as well as on beneficiaries and providers. We introduced that last time in the March report and that holds going forward.

I will start out by briefly reviewing some of the characteristics of Medicare spending discussed at the beginning of the paper. Medicare is expected to spend about \$272 billion in 2003, and this is just program spending, not what beneficiaries pay out-of-pocket.

The spending is concentrated on certain specific services. 40 percent of Medicare spending goes for hospital services inpatient, another 17 percent goes to physicians, and then M+C, SNF, and home health, as well as outpatient hospital care, are some of the other big service areas.

Depending on the service sector, Medicare can account for about 30 percent of revenue and the supplies for hospitals, home health agencies, and DME suppliers. And it can be a much smaller factor for other types of providers. For example, it's about 12 percent for SNF, for nursing homes, and about 2 percent for prescription drugs overall,

but certainly some prescription drugs rely a lot more on Medicare than others.

The costliest 5 percent of beneficiaries account for about 47 percent of spending in any one year, while the least costly 40 percent of beneficiaries accounts for about 1 percent of spending. We'll try and get these numbers for you over a five-year period, like we did last year. We just don't have those at the moment.

Spending varies geographically, as we talked about for last June's report, with Medicare paying an average of about \$3,500 per fee-for-service beneficiary in Santa Fe and about \$9,200 in Miami.

Now let's turn to Medicare spending growth. Let me hit a couple of technical aspects first. On this slide, we use OACT, the Office of the Actuary from CMS. We used their numbers for current and historic spending and CBO numbers for projected spending. The OACT numbers are on an incurred basis, and CBO's are on a cash basis. It accounts for some differences in year-to-year growth that you might see on the two baselines. Again, these are program payments, now what the beneficiaries are spending.

One other point to note, just as you did last year when we were talking about this, is the projections are uncertain. And certainly the further out we get in these projections, the more uncertain they are.

So with that caution in mind, let's just review. After growing an average of about 9.3 percent annually from 2000 to 2002, Medicare spending is expected to grow 4.3 percent in 2003. This relative slowdown is largely explained by the expiration of a number of provisions of the BBRA and BIPA which had increased payments to providers. So now those have expired and payments have gone down. As you can see, spending growth for SNFs and home health agencies is negative. That is particularly where we saw some of those expired provisions.

Between 2004 and 2013, however, the picture quickly changes, resuming more traditional Medicare growth rates of about 6.9 percent over the rest of the projection window.

As you can see in this chart, with projected 6 percent average annual spending growth, Medicare annual spending mounts quickly to about \$525 billion nominally by 2013. That's almost double the spending level today.

This chart sort of understates a long-term trend. It ends in 2013 and that's just two years after the leading edge of the baby boomer generation is retired.

These numbers also assume current law. So for example, they do not include a Medicare prescription drug benefit which, as you may recall, CBO has scored to be between \$405 billion and \$421 billion depending on the bill over the 2004 to 2013 period.

While it isn't on the slide here, let me give you a sense of the projected federal budget deficit during this same period. According to CBO, under current law the deficit is expected to peak in 2004 and then change -- I'm sorry. It peaks at about \$480 billion in 2004 and returns

to surpluses after 2010. But this could quickly change under an alternative scenario, and let me give you just an example. If all tax provisions were extended and a Medicare drug benefit were enacted, the budget outlook for 2013 would change from a surplus of \$211 billion to a deficit of \$324 billion.

With this Medicare spending growth comes some other noteworthy statistics. The HI Trust Fund is expected to be insolvent in 2026. This is four years earlier than was projected last year, and it's in part related to some increased spending assumptions but also largely reduced revenue assumptions.

Medicare is also expected to grow as a percent of the budget from 13 to 15 percent between 2003 and 2013, and Medicare is also expected to comprise a growing portion of the economy, growing from 2.6 percent of GDP in 2002 to 5.3 in 2035 to 9.3 in 2077.

I just want to reiterate the point on the uncertainty about long-term projections by providing example of how even a small difference in the assumption in the long-term growth rate can make a big difference in this statistic. For example, if the growth was assumed to be just a half point percentage faster, Medicare would account for about 13 percent of GDP in 2077 compared to the 9 percent that they're assuming now.

Other sources of health care spending have been and are expected to grow rapidly. Personal health care spending is expected to increase 7.1 percent annually between 2002 and 2012. And at this rate, that means that personal health care spending would comprise about 17 percent of GDP.

Private insurance spending, similarly, is growing fast. It increased about 8 to 9 percent in 2002, which is quite high but it is representing a decrease from one year to the next. And that is the first time we've seen a decrease in the growth rate on an annual basis in quite a while.

Premiums are also showing signs of hitting their peak, perhaps in 2002 or 2003, it really depends on the survey that you're looking at. But certainly passing the peak of increase provides very little relief. We're still talking about premium increases expected to be in the 14 to 17 percent range in 2004, based upon recent employer surveys.

CalPERS, just looking at some of the other governmental purchasers, are looking at big increases, too. They've just announced a 16.4 average increase for its 2004 beneficiaries. While we don't have the FEHBP increase for 2004, it did increase at 11 percent last year, so they too are struggling.

Just quickly, we can review some of the factors that are contributing to health spending growth. A lot of them are the same regardless of who's paying. Technological change, as well as growing consumer and supplier-induced demand, certainly have contributed to past growth rates and are expected to contribute to further growth.

We just would note that the different payers have availed themselves of different cost containment tools and have had varying successes with them. Certainly Medicare has relied a lot on legislation recently that has reduced provider payments, while the private sector has had other tools. They've relied on managed care in the 1990s to control costs. And then more recently, with managed care's retreat and further escalating costs, private payers are increasingly relying on increasing beneficiaries' cost sharing. So we've seen increases in the number of payers that have raised their deductibles, the three-tier copayments they're using now, and requiring more beneficiaries to pay a larger portion of their premiums.

Looking across different payers, it's tempting to compare growth rates to gain an insight into which payers are more successful in containing costs. This has certainly been the topic of many articles and public forums. We would just note that this can be a little dangerous because the comparison must recognize some of the differences across these payers.

First, Medicare and private payers cover different benefits. Certainly prescription drugs is noteworthy, that Medicare doesn't cover that to the extent that the private sector has. When this is taken into account, if you just compare physician and hospital spending, for example, it appears that Medicare grows somewhat slower than private payers over the long run. But this analysis is still compromised by its inability to reflect changes in the generosity of the benefit package over time.

Just to understand this concept real quickly, imagine that the total spending for care is divided between the insured and the beneficiaries in terms of their cost sharing, and just take out premiums for the moment. We're just just talking about spending and who spends.

To the extent that that share of spending shifts between the two parties, spending growth by the insurer will be effective. They're not spending as much if the beneficiary has higher coinsurance. But it says nothing about their ability to contain costs.

So we just really caution you on relying too much on these numbers because they just cannot take into account those kind of fluctuations. We think there have been those kind of fluctuations, especially with the private sector over the last 10 to 15 years.

Also, it depends on the time period that you examine. You can see from this slide that it varies very much, depending on what years you look at, who grows faster.

Another issue clouding this is the fact that some of the private health insurance includes spending for Medicare beneficiaries, in terms of supplemental insurance from employers and Medigap.

Now, I will just switch gears a little bit and turn to data we have on the roll and availability of supplemental insurance. We provide this information because it relates both to access and to out-of-pocket spending of beneficiaries, the two other areas that we're going to talk

about in this chapter. Right now, the data that we have is 2000 MCBS data and we're going to be updating that by December. So this is still just a little bit of a preview of what you'll see in future drafts.

Supplemental insurance gives beneficiaries greater access to care. For example, beneficiaries with Medicare only, and that means no supplemental insurance, were more likely to report delay in care due to costs and having no usual source of care than beneficiaries with supplemental coverage. What is somewhat perhaps more counter-intuitive, however, is that beneficiaries with supplemental insurance are not shielded from out-of-pocket spending. Those with employer-sponsored insurance, as well as with Medigap, tend to use more services and have higher out-of-pocket costs.

The most common sources of supplemental insurance are employer-sponsored coverage with about a third of beneficiaries having that, Medigap 27 percent, and M+C has about 18.3 percent. And this is in 2000. 11.6 percent had Medicaid and about 9.3 percent had Medicare only.

It's important to remember that these numbers are only estimates and data from other surveys suggests that the Medicare percentage could possibly be higher than the number here that we report.

Just real quickly, to go over some of the trends in supplemental insurance and its availability. It seems as if employer-sponsored insurance is declining. We've seen this in employer surveys more and more, saying that for future retirees they're not going to be covering them. And a new study has found that in the younger cohort of the Medicare population, the 65 to 69-year-olds, that is starting to show up, that fewer have supplemental coverage from their employer.

M+C enrollment peaked in 1999 and has declined since. And the cost sharing associated with that option has decreased, also. Fewer plans are offering zero premiums and coinsurance is increasing, also.

Medigap premiums are increasing about 10 percent we estimate between 2000 and 2001 for the two most popular plans. We've seen a small increasing from year-to-year between 1999 and 2000 in the number of Medicare only, from about 8.8 percent to 9.3 percent.

But we're certainly interested in looking forward as to where people are moving to, if they have less access to employer-sponsored insurance, if they're finding mounting Medigap premiums as daunting. And M+C may not be as available. So we'll be looking at that when we get a hold of the 2001 MCBS data.

With that, I think I'll just close here and just ask for any comments that you have on content and tone.

DR. ROWE: Well, just one comment which really echoes what you just said, Anne, about getting the new data. These are changing issues, to be citing what proportion of the Medicare beneficiaries have M+C and using 2000 data, is really a number which as we all know is not the current number. And maybe there are some ways to refresh it up a little bit or make some estimates or something. After all,

this is MedPAC and people are going to -- we should be as up-to-date as we can be.

I just have one contextual comment, and that is in your remarks you said that insurers were forcing employees to pay a higher share of the premium. And I would offer that it is employers who are forcing employees to pay a higher share of the premium. We have a lot of people blaming us for everything but we don't need that MedPAC also blame us. It is really the employer's decision what proportion of the health care cost the employer pays and how much gets pushed across the table. And it's the employer's decision as to the benefit design of the health plan products that they offer their employees when they do offer them.

So I think it would be fair -- --

MS. MUTTI: I apologize for that, Jack. I misspoke there.

DR. ROWE: I didn't take a personally, I just want to make sure we understand.

MS. ROSENBLATT: I like this chapter and I thought it was very well done previously, and I think updating it is a great idea. I think putting it all in context is terrific and I like the fact that you brought in the \$400 billion for the drugs.

There is one issue, you gave a lot of caveats about your chart that compares spending among the different private health insurance, et cetera. There is another caveat in that I believe that we are comparing things that relate to each other. So that if you look at chart 1.2, which unfortunately you didn't have in your overheads but it's in the package we got, as Medicare increases go up, private goes down and vice versa. There's that inverse relationship all the time.

So if you're comparing how Medicare does on controlling costs with how commercial payers do, there's always well, wait a minute. How can we compare something that's really related because if the providers are getting less from Medicare, they're going to try to get more from commercial.

So, I think that might be a good caveat to add.

DR. REISCHAUER: This is a draft that's filled with lots of interesting bits of information and I'm going to be a nit-picker here and, like Jack, defend the roots that I have. And that is sort of your use of some terms like CBO and the trustees forecast that Medicare will grow 1 percent faster than GDP in the future. They assumed that. They don't really forecast it. It's a number pulled out of the sky and everything you have provided later on suggests that it really is in the sky.

Where you talk about Medicare as a percent of federal spending, you say it's going to grow from 13 to 16 percent. It's expected to. But we all know the base which you're using is woefully unrealistic because it's the CBO baseline. So I think we mislead people.

And similarly, I applaud you for pointing out that the baseline later on is a little fanciful, and then you

give a number for the likely deficit in 2013 which is \$324 billion if the tax cuts are extended and there's a prescription drug benefit. But that number that you're using also assumes that discretionary spending grows no faster than inflation. And if it grows at anywhere near what the past five years has been, the deficit in the CBO numbers is well over \$700 billion. So I think if we're going to strive for realism, we should go all the way.

You have a little statement about specialty hospitals and clinics are flourishing as providers. I guess I could be dead wrong on this, but something I read -- I think it was by Paul Ginsburg's folks -- laid out how many specialty cardiac hospitals there were in America right now. And I think I can count them on the fingers of both hands, and the fraction of total cardiac services that they provide must be absolutely tiny.

It's something new. It's something that's developing very rapidly. But like the PLI, it's starting from such a small level that the impact that it's going to have on the great swath of health care in America is likely to be rather limited.

So what I'm saying is I don't think we should make things sound bigger than they are.

MS. MUTTI: Flourishing might have been a poor choice of words.

DR. ROWE: Is that really all there are? There's only a couple of handfuls?

DR. REISCHAUER: Like a dozen or eight. I could be wrong. I mean, there's undoubtedly somebody in the audience who knows what these numbers are.

MS. BURKE: [off microphone] But the point is it's not just those. I mean, you've got LTACs --

DR. REISCHAUER: Cardiac specialty hospitals. There's a bunch on the drawing boards.

MS. DePARLE: It's not as big as I thought.

DR. REISCHAUER: But it says it's small, too.

DR. MILLER: I think the thought that were trying to capture, and we may not have constructed the words right, is if you think of specialty to Sheila's point, more broadly than just these facilities, like long-term care hospitals and that kind of thing, that is I think the phenomena we were trying -- and we may have put just the words cardiac or whatever we put in there. But I think we're thinking more what Sheila said.

DR. ROWE: [off microphone] It's a small but rapidly growing --

DR. REISCHAUER: But even those are not huge.

I had one question about data which just struck me when I was reading this for the first time, and this was the chart on additional coverage for selected beneficiaries. In all these tables we and everybody else has this employer-sponsored insurance. I was interested in the breakdown that you had by age.

I was wondering if there's any way to ferret out active workers who are getting employer-sponsored insurance, as a way of trying to figure out sort of what the future

looks like. Because in these numbers you see that people 65 to 69, a higher fraction of them have employer-sponsored insurance, even though we know employer-sponsored insurance for retirees is a declining benefit. And it must be that what we're picking up in these numbers is a lot of 66-year-olds who are still in the work force have signed up for Part A, at a minimum. And if it would be possible to take them out of the analysis.

MS. ROSENBLATT: I don't know you can do that but just to your point, I think that what is happening is that employers are not kind off their current retirees. They're cutting off their future retirees.

DR. REISCHAUER: They've grandfathered everybody and often it's everybody over age 55 or over age 60. But we've been talking about this now for about six or seven years, so they should begin to be showing up in these numbers. And I was just surprised that it wasn't more apparent. And you have some other information here, from other sources.

MS. MUTTI: Right, that does show that, looking over a five-year period. And we just have one year right here.

DR. WOLTER: I was just going to suggest maybe, as we continue to work in this context in the future, it's interesting to look at the interplay between Medicare and private insurance and the private sector. We might want to add some information on trends in the uninsured and possibly a little bit more in the Medicaid arena. There's one table that captures some Medicaid data, but a lot is happening there, also. And as we use this to maybe ultimately get at some of the interplay between these various sectors, adding those two things would be useful, I think, to people.

MS. MUTTI: We had planned to come back on Medicaid, but the uninsured is a new idea.

DR. WAKEFIELD: Anne, when you give us more information about the shift in Medicare only that is the decline in Medigap coverage -- Medicare only increasing 8.8 to 9.3 percent -- will you be able to tell us anything or not about any changes in that group's utilization of health care services or access to care?

MS. MUTTI: Yes, we should be able to.

MS. RAPHAEL: I found this very interesting, in terms of the part where you try to compare the methods used to control future growth in the private sector compared to Medicare's use of legislation. And I was wondering if you have any evidence at all about what the impact is of the private sector employers' attempts to increase cost sharing? Because you allege that we think that shielding employees from cost might lead to greater utilization. At least that's the hypothesis.

So we do we know if the reverse is true? By increasing cost sharing, in fact, utilization of services has decreased?

DR. ROWE: I think I can comment on that. I think it's important to differentiate the forms of cost sharing. If your employer decides to go from 85 percent of the

premium paid by the employer to 80 or even 75 on an annual basis out of your paycheck, that has a very different effect on utilization than if they choose a different plan design that has coinsurance or a higher copay or deductible at the point of the clinical service.

So you could, in fact, have two different designs where there's the same reduction from 85 to 75 percent. But one of them influences a decision making at the point of clinical service. Should I get a generic drug or a brand drug? Should I go to the emergency room with my sprained ankle or not? And another doesn't, because it's just out of the paycheck.

And so when you do that analysis or try to answer that question, it's very important to differentiate those two different ways in which employers are increasing the cost sharing. And I think you'd find, with the latter type, where it's the product design that, in fact, you would find reductions in utilization and they're quite predictable actually. Any actuaries can -- well, Alice can comment on this.

If you do just in terms of the cost sharing out of the salary, then I think it's much harder to demonstrate that. Alice?

MS. ROSENBLATT: I agree. Out of the salary, it's just going to affect who picks what. Whereas out of the benefit plan, it does have decreased utilization. How predictable it is, I'm not sure. But you can look at it and see, the utilization change will be more than the strict actuarial difference of the benefits. In other words, if you change your deductible from \$200 to \$400 and just expect to see the \$200 difference, you're going to see more than that.

MS. RAPHAEL: That's helpful.

DR. NEWHOUSE: This is really comment on Alice and Nick's point about the link between public and private. While it's certainly right that in the short run there's a negative relationship between what Medicare pays and what the private sector charges, in the longer run politics in Medicare dictate that Medicare is going to keep up with private sector or keep some relationship with it to preserve access for Medicare beneficiaries.

So if we're going to talk about the relationship, and I think we probably should because they are related, we need to distinguish short and long run.

MR. HACKBARTH: And for each there's sort of a cyclical element having to do with underwriting cycle and other factors, maybe on the private side. In Medicare there are political cycles of budgetary stringency and generosity. And so I think any comparison, to be meaningful, would really look at a fairly long period of time. And then it still has all the caveats that have been identified.

MS. BURKE: Two quick questions, one a follow-up to Nick's point about future versions of this perhaps reflecting in greater depth on Medicaid because of the obvious linkages there.

My one cautionary note, this document is

enormously useful and it is designed to assist us in looking at the broad context in which Medicare must be considered. I think we need to be careful about how many linkages we create.

To the extent that we do Medicaid, to extend that we do the uninsured, goes back to a much bigger question and that is to what extent should Medicare, in fact, adjust or reflect those behaviors and how it, in fact, deals with the costs that are being incurred by efficient providers.

So I think Nick is exactly right, but the cautionary note is how tightly we create that link. This happened and the cause and relationship with Medicare is just one I think we should be sensitive to. But I do think it would be very helpful to give the broad context.

The other is, in fact, something very nit-picky, and Bob may actually have a thought on this. In the section where you discuss demographics and economic trends, there is a number that has been used largely in the context of Social Security, but is sort of an interesting way to look at what the impact of the changing demographics is. That is the actual number of retirees to workers, in terms of the ratio. I mean again, it's largely used in the context of Social Security, where it began in terms of the contributions and then where it's gone.

But it's interesting, we're down to what, two to one now or three to one? Three to one? I think it's just a quite easy description of how quickly that has changed and how dramatic that impact is likely to be in terms of the financing system.

MR. FEEZOR: Anne, a good chapter. I'm sorry I was not in for your presentation and I have a couple of edits that I'll send you in written form.

One though, just on page three of the materials that you sent us, you talk about the geographic variation in price and a lot of that is really due to practice pattern differentiation. Any way of sort of quantifying what that deviation may be? Say about an average what the aggregate cost would be to the Medicare program? Just think about it.

DR. ROWE: You can always do Miami and Minnesota.

MR. FEEZOR: No, that's -- well, we do New Mexico and something above, Detroit. More in terms of, I think, what the average cost.

One other thing. As we go forward in the subsequent editions of this chapter, are the databases sufficiently sensitive to any tilt towards either MSAs or particular FSAs? And I guess I'm concerned, having I guess a recent IRS ruling which in fact is going to expand the applicability of at least flexible spending accounts to be a lot of non-prescription and a lot of non-things. I've got a whole bunch of herbal drugs that I was, in fact, going to immediately submit on my FSA.

DR. ROWE: Some of those are illegal, you know.

MR. FEEZOR: Fortunately, I brought most of them from California, so I'm still in good shape.

But just as a cautionary note, I think in terms of our thinking of capturing some of that personal expenditure

data going forward, that I think some either expansion or refinement of some of the FSA expenditures may be warranted there as we go forward.

DR. NELSON: Anne, maybe you can help me with some confusion over terms, around the term personal health care expenditures or personal health care spending. Because it appears to me that they are used in two different ways. One, in the comparing growth chart which has personal health care expenditures, and I want to know what you mean by that.

And then, in the Medicare spending characteristics on page one you define personal health care spending as all money spent on clinical and professional services received by patients excluding administrative costs and profit, with Medicare comprising 19 percent of that.

Are they the same? Or is a personal health care expenditure referring to uncovered expenses out-of-pocket by individuals?

MS. MUTTI: No, they are the same. It is all spending on health care services. It sounds technical because we're taking out the administrative costs. We're taking out public health spending because we're looking nationwide. We're taking out some research money.

So we're trying to just focus on that money which is spent for health care services, clinical services. So it is true then that Medicare is 19 percent of all that money that is spent on that.

And then when we have that other chart where we showed the growth rate of how fast that is growing, it's the same pot of money that we're just showing annual growth.

DR. NELSON: Thank you, that's helpful.

DR. REISCHAUER: I think it's national health expenditures minus construction, research, education, public health, but administrative costs associated with delivery of care are included.

MS. MUTTI: That may be true. I was just looking at the chart right before the meeting to try and figure out what was in there and I may have misread how indented that line was inclusive or not. But I'll go back and double check.

DR. REISCHAUER: I'm not 100 percent sure.

MS. MUTTI: Or the label may have been misleading. I'll double check.

MR. SMITH: Anne, as usual, this is very helpful stuff.

One set of comparisons which we might think about whether or not we could add and the utility of adding, would be the Medicare covered population and everybody else. That what's going on both with insurance and utilization in the rest of the population, partly to Joe's point, that there is a political imperative for Medicare either not to lag too far behind nor to lead.

But there are profound changes going on in the way everyone else is covered. And it might be useful to look at the Medicare covered and the non-Medicare covered population.

To Sheila's Social Security point, it's too easy,

I think. The real metric here is personal income, not ratio of workers to beneficiaries. I'd be very careful with that ratio. The issue is personal income, share of personal income. So I'd stay away from that.

MR. HACKBARTH: Okay, thank you, Anne.

Next up is our work plan for assessing quality of care. Karen.